

STANDARD CERTIFICATE OF DEATH

FILED APR 2 - 1957

STATE FILE NUMBER **8656**
 Registrar's No. **1172**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St Mary's Hospital		Length of stay in 49 yrs	d. STREET ADDRESS 341 No Drury		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PAUL Middle L Last FEAGANS			4. DATE OF DEATH Month March Day 12 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23 1879	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mo Pacific R R	11. BIRTHPLACE (City and state or country) Linn Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Feagans			14. MOTHER'S MAIDEN NAME Mattie Davis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 702-14-9803	17. INFORMANT Address Mrs Ethel Feagans 341 No Drury		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchial pneumonia					INTERVAL BETWEEN ONSET AND DEATH 48 hours
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) cerebral thrombosis					March 1, 1957 33 1/2 years
DUE TO (c) generalized arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from Feb. 6, 1957 to March 12, 1957 and last saw ^{free} him alive on March 12, 1957 . Death occurred at 2:45 p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. E. Castles</i> (Degree or title)		22b. ADDRESS M. D. 1002 Argyle Building		22c. DATE SIGNED 3/13/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 15 1957	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo.		25. DATE RECD. BY LOCAL REG. 3-13-57	25. REGISTRAR'S SIGNATURE <i>Olva Minshall</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 J. E. Castles

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with distinctive diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Thomas A. Smith*.....

Licensed Embalmer No. *412*

P. O. Address *K.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.